FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 8000200

Facility Name: Graham Hospital

Address: 210 West Walnut (Number) Canton, IL (City) 61520-2497 (Zip Code)

County: Fulton

Telephone Number: (309) 647-5240 **Fax #** (309) 649-5111

IDPA ID Number: 37-0673506-004

Date of Initial License for Current Owners: 07-02-1987

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Melissa Wilson **Telephone Number:** (309) 647-5240 ext. 2256

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2002 to June 30, 2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Melissa Wilson
(Title) Director of Accounting

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds No Change

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	32	Skilled (SNF)	32	11,680	1
2		Skilled Pediatric (SNF/PED)			2
3	22	Intermediate (ICF)	22	8,030	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	54	TOTALS	54	19,710	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	394	796	8,080	9,270	8
9	SNF/PED					9
10	ICF	1,926	5,642	1	7,569	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,320	6,438	8,081	16,839	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.43%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/1987

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 8,080

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/03 Fiscal Year: 6/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	210,576	151,526		362,102		362,102		362,102			1
2	Food Purchase		226,219		226,219		226,219		226,219			2
3	Housekeeping	2,012	1,543		3,555		3,555		3,555			3
4	Laundry	11,119	144,439		155,558		155,558		155,558			4
5	Heat and Other Utilities											5
6	Maintenance	122,793	224,243		347,036		347,036		347,036			6
7	Other (specify):*											7
8	**TOTAL General Services**	346,500	747,970		1,094,470		1,094,470		1,094,470			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,487,522	111,993		1,599,515	(66,235)	1,533,280		1,533,280			10
10a	Therapy											10a
11	Activities											11
12	Social Services											12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*	52,536	15,948		68,484		68,484		68,484			15
16	**TOTAL Health Care and Programs**	1,540,058	127,941		1,667,999	(66,235)	1,601,764		1,601,764			16
	C. General Administration											
17	Administrative					66,235	66,235		66,235			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	197,708	198,438		396,146	(29,656)	366,490		366,490			21
22	Employee Benefits & Payroll Taxes			375,443	375,443		375,443		375,443			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			126,406	126,406		126,406		126,406			26
27	Other (specify):*											27
28	**TOTAL General Administration**	197,708	198,438	501,849	897,995	36,579	934,574		934,574			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,084,266	1,074,349	501,849	3,660,464	(29,656)	3,630,808		3,630,808			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Graham Hospital #8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			116,421	116,421		116,421	254,388	370,809			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			116,421	116,421		116,421	254,388	370,809			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			941,885	941,885		941,885		941,885			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					29,656	29,656		29,656			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			941,885	941,885	29,656	971,541		971,541			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,084,266	1,074,349	1,560,155	4,718,770		4,718,770	254,388	4,973,158			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	254,388	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 254,388		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 254,388		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Graham Hospital

ID# 8000200

Report Period Beginning: July 1, 2002

Ending: June 30, 2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Graham Hospital # 8000200 **Report Period Beginning:** July 1, 2002 **Ending:** June 30, 2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Graham Hospital # 8000200 **Report Period Beginning:** July 1, 2002 **Ending:** June 30, 2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	254,388	0	0	0	0	0	0	0	0	0	0	254,388	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	254,388	0	0	0	0	0	0	0	0	0	0	254,388	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	254,388	0	0	0	0	0	0	0	0	0	0	254,388	45

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
GRAHAM HOSPITAL ASSOCIATION	100	NONE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	NOT APPLICABLE										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: ne 30, 2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: ne 30, 2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Graham Hospital COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 8000200

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Graham Hospital COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 8000200

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,668 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	ECF/SNF	16,668	VARIOUS	$ 22,356	1
2					2
3	TOTALS	16,668		$ 22,356	3

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1971		$ 1,047,221	$ 121	VARIOUS	$ 121	$	$ 1,047,221	4
5			1972		866					866	5
6			1975		30,771					30,771	6
7			1976		1,880					1,880	7
8			1977		1,331,168	29,232		29,232		947,541	8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36					2,411,906	29,353		29,353		2,028,279	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1978		$ 187,881	$ 1,104	VARIOUS	$ 1,104	$	$ 50,798	4
5			1980		2,093	45	23	45		2,093	5
6			1982		5,227		15			5,227	6
7			1984		1,169,963	41,368	VARIOUS	41,368		833,016	7
8			1985		34,258	1,713	VARIOUS	1,713		31,689	8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36					1,399,422	44,230		44,230	0	922,823	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1987		$ 89,317	$ 1,682	VARIOUS	$ 1,682	$	$ 82,137	4
5			1988		48,518	96	VARIOUS	96		48,377	5
6			1990		28,254	368	VARIOUS	368		27,615	6
7			1991		125,804	6,620	VARIOUS	6,620		96,739	7
8			1992		16,693	1,503	VARIOUS	1,503		14,771	8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36					308,586	10,269		10,269	0	269,639	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993		$ 19,686	1,070	VARIOUS	1,070	$	$ 11,688	4
5			1994		76,132	5,001	VARIOUS	5,001		61,115	5
6			1995		32,594	2,093	VARIOUS	2,093		26,565	6
7			1996		47,691	4,121	VARIOUS	4,121		36,188	7
8			1997		24,479	2,078	VARIOUS	2,078		17,184	8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36					200,582	14,363		14,363	0	152,740	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1998		$ 26,173	$ 2,190	VARIOUS	$ 2,190	$	$ 15,036	4
5			1999		11,097	608	VARIOUS	608		2,737	5
6			2000		800,069	53,938	VARIOUS	53,938		188,784	6
7			2001		112,532	12,564	VARIOUS	12,564		22,379	7
8			2002		580,999	41,765	VARIOUS	41,765		61,910	8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36					1,530,870	111,065		111,065	0	290,846	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2003		$ 356,376	$ 7,997	VARIOUS	$ 7,997	$	$ 13,133	4
5											5
6											6
7											7
8					6,207,742	217,277		217,277	0	3,677,460	8
	Improvement Type**										
9	VARIOUS			1971	644,233	0	VARIOUS	0		644,233	9
10	VARIOUS			1977	1,416,541	0	VARIOUS	0		1,416,541	10
11	VARIOUS			1983	114,728	2,032	VARIOUS	2,032		114,728	11
12	VARIOUS			1984	1,543,912	50,565	VARIOUS	50,565		1,524,024	12
13	VARIOUS			1986	2,699	135	VARIOUS	135		2,355	13
14	VARIOUS			1987	287,339	10,644	VARIOUS	10,644		276,070	14
15	VARIOUS			1988	14,161	634	VARIOUS	634		11,726	15
16	VARIOUS			1989	11,786	44	VARIOUS	44		11,764	16
17	VARIOUS			1990	13,887	731	VARIOUS	731		12,756	17
18	VARIOUS			1991	7,249	232	VARIOUS	232		4,899	18
19	VARIOUS			1992	23,953	542	VARIOUS	542		17,836	19
20	VARIOUS			1993	21,263	1,326	VARIOUS	1,326		18,418	20
21	VARIOUS			1994	91,510	6,506	VARIOUS	6,506		61,809	21
22	VARIOUS			1995	8,871	1,071	VARIOUS	1,071		8,871	22
23	VARIOUS			1996	29,760	3,150	VARIOUS	3,150		24,133	23
24	VARIOUS			1997	91,231	8,928	VARIOUS	8,928		58,400	24
25	VARIOUS			1998	50,984	3,801	VARIOUS	3,801		21,093	25
26	Hoist cables/load test elevators			1999	4,196	837	5	837		3,767	26
27	A/C for OB/Surgery			1999	11,375	12	10	12		53	27
28	Repair/ clean boiler			1999	3,178	159	20	159		713	28
29	Plumbing for Print Shop remodel			1999	1,446	72	20	72		325	29
30	Exhaust fan for Print Shop remodel			1999	602	60	10	60		271	30
31	Generator auto transfer switch			1999	5,275	526	10	526		2,368	31
32	Remove underground tanks			1999	1,969	98	20	98		443	32
33	Pivor point for elevator			1999	684	68	10	68		307	33
34	Upgrade air handling system			1999	14,696	1,466	10	1,466		6,597	34
35											35
36					10,625,270	310,916		310,916	0	7,921,960	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 10,625,270	$ 310,916		$ 310,916	$	$ 7,921,960	1
2	A/C for OB Surgery	1999	11,256	1,123	20	1,123		5,052	2
3	Oxygen Outlets	2000	2,063	103	20	103		361	3
4	A/C Repair	2000	2,136	214	10	214		748	4
5	Control/air compressor	2000	610	41	15	41		142	5
6	Motor for chilled water pump	2000	254	25	10	25		89	6
7	Alarm installation	2000	2,460	164	15	164		574	7
8	Fire supression system	2000	1,291	86	15	86		301	8
9	Night call switch	2000	601	60	10	60		210	9
10	Motion detector for south doors	2000	706	71	10	71		247	10
11	Nurse call system	2000	2,839	284	10	284		994	11
12	A/C Repair	2000	1,317	132	10	132		461	12
13	Phone switch upgrade	2000	2,908	291	10	291		1,018	13
14	Sediment filters for PT Dept.	2001	944	94	10	94		236	14
15	Hotwater heater installation	2001	26,002	2,600	10	2,600		6,500	15
16	Boiler Replacement	2001	242,941	12,200	10	12,200		30,498	16
17	GE CT Scan	2001	10,183	1,018	10 to 20	1,018		2,546	17
18	PT Dept. electric & duct work renovation	2001	4,116	206	10	206		515	18
19	Pump W/discharge head & 20 HP motor	2001	3,014	301	20	301		753	19
20	Air conditioner-surgery	2001	7,620	762	10	762		1,905	20
21	A/C system-finance	2001	19,738	1,974	10	1,974		4,934	21
22	Exhaust system	2001	774	52	10	52		129	22
23	Air conditioner-dialysis	2001	8,545	855	15	855		2,136	23
24	A/C Controller	2001	1,084	108	10	108		271	24
25	Air conditioner-surgery	2001	8,842	884	10	884		2,210	25
26	Carrier-air conditioner	2001	9,233	923	10	923		2,308	26
27	Air conditioner-dialysis	2001	10,019	1,002	10	1,002		2,505	27
28	Compressor w/monitors	2001	7,603	507	15	507		1,267	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,014,369	$ 336,996		$ 336,996	$	$ 7,990,870	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 11,014,369	$ 336,996		$ 336,996	$	$ 7,990,870	1
2	Radiology renovation - electrical wiring	2002	1,607	80	20	80		121	2
3	School of Nursing renovation - electrical	2002	645	32	20	32		48	3
4	Home Health 24 port 4400	2002	1,807	361	5	361		542	4
5	Home Health run electrical	2002	6,867	1,500	5	1,500		2,060	5
6	Home Health exit lights	2002	1,437	144	10	144		216	6
7	Home Health electrical co.	2002	2,247	112	20	112		169	7
8	Infrared Detectors for #2 elevators	2003	1,446	36	20	36		36	8
9	Compressor for 400 Ton chiller	2003	3,194	151	15	151		106	9
10	Hoist ropes for elevator 2	2003	1,439	36	20	36		36	10
11	New Pit channels and buffers	2003	1,273	32	20	32		32	11
12	Phone system software	2003	1,968	98	10	98		98	12
13	Elevator 3 Upgrade	2003	1,243	31	20	31		31	13
14	Paging system	2003	1,248	31	20	31		31	14
15	Upgrade Elevators 5 & 6	2003	64,842	1,621	20	1,621		1,621	15
16	Elevator 3 Upgrade	2003	2,763	69	20	69		69	16
17	Elevator 2 Upgrade	2003	460	12	20	12		12	17
18	Acute Care renovation Pipe/ Electrical	2003	505	13	20	13		13	18
19	Acute Care renovation Sprinkler system	2003	25,452	688	25	688		688	19
20	225 Ton A/C replacement water meter	2003	627	31	10	31		31	20
21	225 Ton A/C replacement 120V starter	2003	786	39	10	39		39	21
22	225 Ton A/C Replacement Prof Serv/ HVAC	2003	192,704	6,424	15	6,424		6,424	22
23	225 Ton A/C replacement repair pump	2003	874	44	10	44		44	23
24	Hot Water Heater	2003	7,187	359	10	359		359	24
25	Radiology renovation - automatic sprinkler	2003	545	11	25	11		11	25
26	Acute care reno - air balancing	2003	784	26	15	26		26	26
27	Acute care reno - phillips HVAC study	2003	1,925	64	15	64		64	27
28	Acute care reno - HVAC/ Plumbing	2003	28,485	712	20	712		712	28
29	Acute care reno - hot water mains/ duct work	2003	36,409	728	25	728		728	29
30	225 Ton A/C replacement - supplies	2003	1,197	30	20	30		30	30
31	225 Ton A/C replacement - remove/install tank	2003	3,637	73	25	73		73	31
32	225 Ton A/C replacement starter w/fact modi	2003	1,620	54	25	54		54	32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,411,592	$ 350,638		$ 350,638	$	$ 8,005,394	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 220,005	$ 18,528	$ 18,528	$		$ 101,625	71
72	Current Year Purchases	30,555	1,643	1,643			1,643	72
73	Fully Depreciated Assets	86,043					86,043	73
74								74
75	TOTALS	$ 336,603	$ 20,171	$ 20,171	$		$ 189,311	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,770,551	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 370,809	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 370,809	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,194,705	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,179,605	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1375000)	5,294,593		3
4	Supply Inventory (priced at cost using FIFO)	483,995		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	321,000		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Medicare	170,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,449,193	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	29,630,184		12
13	Land	2,444,109		13
14	Buildings, at Historical Cost	20,048,737		14
15	Leasehold Improvements, at Historical Cost	12,336,014		15
16	Equipment, at Historical Cost	17,579,624		16
17	Accumulated Depreciation (book methods)	(33,536,595)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	53,458		21
22	Other Long-Term Assets (spe L/T Receivables	1,172,758		22
23	Other(specify): Beneficial Interest perp trust	7,971,128		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 57,699,417	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 66,148,610	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 940,147	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	2,786,476		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,726,623	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Est. Self Insurance Costs	1,194,577		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,194,577	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,921,200	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 61,227,410	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 66,148,610	$	48

***(See instructions.)**

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 60,732,582	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 60,732,582	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,685,748	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	112,560	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Change in unreal loss on investments**	504,349	15
16	Other (describe) **Decrease in interest in perpetual trusts**	(168,172)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,134,485	17
	B. Transfers (Itemize):		
18	**Transfer to Affiliate**	(1,639,657)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,639,657)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 61,227,410	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 65,738,977	1
2	Discounts and Allowances for all Levels	(30,035,607)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 35,703,370	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	291,806	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	247,579	16
17	Sale of Drugs	260,643	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	467,759	19
20	Radiology and X-Ray		20
21	Other Medical Services	486,861	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,754,648	23
	D. Non-Operating Revenue		
24	Contributions	58,867	24
25	Interest and Other Investment Income***	1,604,223	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,663,090	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	School of Nursing	303,464	28
28a	Gain on disposal of equipment	8,374	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 311,838	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 39,432,946	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services		31
32	Health Care	28,949,231	32
33	General Administration	8,797,967	33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 37,747,198	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,685,748	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,685,748	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)			$ *	$	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2	NONE												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5-10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **NONE** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **29,656**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **BKD, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1971		$ 1,047,221	$ 121		$ 121	$	$ 1,047,221	4
5			1972		866					866	5
6			1975		30,771					30,771	6
7			1976		1,880					1,880	7
8			1977		1,331,168	29,232		29,232		947,541	8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total